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WHAT MARYLAND CAN LEARN FROM OTHER STATES

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SUMMARY

WITH MEDICAID TAKING AN EVER-GROWING SHARE of the Maryland state budget, the time is here for state policymakers to reform the program to ensure its affordability. If not, Medicaid will continue its unchecked growth, guaranteeing budget problems for years to come.

Other states have enacted Medicaid reforms that seem to have produced spending restraint and improved service for Medicaid recipients. Maryland should learn from these states and consider the following remedies:

- Establish a task force to evaluate the variety of options that exist for restricting the state's Medicaid program.
- Demand greater flexibility from the federal government so the state can tailor its Medicaid program to better fit the needs of Marylanders in the program.
- Reform and expand the state's managed care system so that it offers better service and provides greater budget predictability.
- Provide health care coverage in different ways to many who currently receive or who will soon receive Medicaid.

Other states have applied these measures and subsequently improved their Medicaid systems. Maryland policymakers should learn from innovations in other states and use these reforms to help slow the growth in Maryland's Medicaid spending and improve health care services.

INTRODUCTION

Maryland has a problem of too much government spending and too little government revenue. Even though legislators in the 2011 session of the General Assembly raised alcohol taxes and a variety of fees, they did not eliminate the long-term structural deficit. Medicaid spending is one of the major drivers of that deficit. Over 17 percent of the state's revenue is dedicated to paying for this program, up from 13 percent twelve years ago. The growth in Medicaid spending must be addressed if legislators want to stop out-of-control spending.

Maryland's Medicaid situation is not unique. Other states also face similar problems, with Medicaid programs growing dramatically in recent years and putting fiscal pressure on state budgets. Some states have taken steps to reform their Medicaid programs to address this growth. Maryland policymakers should consider these ways restructure its Medicaid program and bring spending under control.

MEDICAID IN MARYLAND

The state of Maryland has five medical care programs:

- Medicaid – Provides health care services to parents in families making under 116 percent of the federal poverty level as well as to those who meet criteria for being "medically needy."

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- Maryland Children's Health Program (MCHP) – Provides medical coverage for children and pregnant women in families making up to 300 percent of the federal poverty level.
- Family Planning Program – Provides certain family planning services to women who were eligible for MCHP when pregnant.
- Primary Adult Care Program – Provides some health services for adults in families making fewer than 116 percent of the federal poverty level who aren't eligible for Medicare or Medicaid.
- Kidney Disease Program – Provides reimbursement for certain procedures needed to treat end-state renal disease.

Among these programs, Medicaid and MCHP have the largest enrollments and receive the bulk of state and federal funding.[1] Enrollment in these programs has been growing. In fiscal year (FY) 2000, the Medicaid enrollment was 427,082 per month and MCHP was 67,331.[2] In FY 2010, there was an average of 676,186 Medicaid recipients per month and 97,988 MCHP recipients .[3] Enrollment will increase in the next two years as the state complies with the new federal health care law mandating that all adults making fewer than 133 percent of the federal poverty level be eligible for Medicaid.

Overall, funding of Maryland's state health programs has steadily increased in the past decade. In fact, spending has increased far more than enrollment growth. In FY 2000, Maryland spent $2.492 billion on its medical care programs: $1.140 billion of this came from the state's general fund, and the rest from the federal government or special funds.[4] In FY 2010, the last year for which there are complete data, Maryland spent $6.004 billion on these programs, with $1.594 coming from the General Fund. The governor's budget for FY 2012 called for $7.099 billion in funding for these programs, of which $2.599 billion would come from the general fund.[5]

From FY 2000 to FY 2012, spending on medical care programs has risen 185 percent and state-only spending on the program has gone up by 128 percent. This spending growth has caused a greater share of the state's general fund revenue to be devoted to them. In FY 2000, 12.6 percent of the general fund was devoted to medical care programs. In FY 2012, these programs' share grew to 17.2 percent of the general fund.

Not only is Medicaid expensive, it also offers poor service to its recipients. Recent studies have found that Medicaid recipients have far worse health care outcomes than do those with private insurance or even the uninsured.[6]

While there have been changes to Maryland's Medicaid program in recent years, the program's only significant difference between today and ten years ago is that more Marylanders are now eligible for services. Where other states have been trying to find new ways to structure their Medicaid programs, Maryland's policymakers have been focused on expanding eligibility.

As the numbers above illustrate, eligibility expansion is costly. To help contain costs, Maryland has cut the payment rates to providers who treat Medicaid patients. Cutting provider payment rates will reduce the state's Medicaid spending but can compromise the quality of care as well as reduce the number of providers serving Medicaid patients.[7]

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If Maryland continues to push down reimbursement rates, eventually there will be too few providers serving recipients, or it will lead to an unacceptably low level of care. Relying on rate reduction to produce savings may not be workable for another reason: evidence demonstrates that when government reimbursement rates are cut, physicians respond by increasing the number of services in order to compensate for the lost income.[8]

Maryland must change its approach in order to bring Medicaid spending under control. Expanding eligibility increases costs, and must be addressed in ways other than cutting provider payments.

LOOKING TO OTHER STATES

While Maryland has shown little desire to innovate its Medicaid program, other states have implemented some partially successful new ideas. New York, Rhode Island, Indiana, and Florida have all explored different ways to reform Medicaid. While not all ideas have succeeded, these states are taking active steps to deal with the fiscal pressures Medicaid has placed on their state budgets. Maryland policymakers can learn much from these states' experiences.

New York

Few states are in a worse position regarding Medicaid spending than New York. In FY 2011, total Medicaid spending will be $53.8 billion, an increase of 127 percent from FY 2000's level of $23.7 billion.[9] In 2010-2011, the governor's budget projects almost 37 percent of the state's general fund revenue spent on Medicaid. The per-capita cost of serving a New York Medicaid recipient ($2,488) is over twice the national average ($1,150).[10]

Enrollment, too, has increased significantly. In 2009, 4.4 million New Yorkers were enrolled in Medicaid, an increase of 63 percent from 2000 (when 2.7 million were enrolled in the program).[11] The passage of the Patient Protection and Affordable Care Act is set to increase enrollment by up to 2.7 million after 2014.[12]

These facts spurred New York Governor Andrew Cuomo to form a Medicaid Redesign Team soon after he took office in 2011. The MRT released a set of 79 recommendations in late February[13] which it estimates will save $1.1 billion in 2011-2012 and $1.5 billion in 2012-2013.

Managed long-term care for Medicaid recipients is promising, and New York has successfully controlled Medicaid spending in this area. In 2003, the cost of Medicaid managed long-term care was $36,143 per enrollee. In 2008 it was $35,988, a decrease of .4 percent.[14] If Medicaid long-term care recipients in the fee-for-service program can be transitioned into managed long-term care, then perhaps this same limit on growth can be maintained, resulting in significant future savings in the Medicaid program.

Other states that have transitioned Medicaid recipients, including those with severe disabilities, into managed care have found significant savings.[15]

In New York, if MRT recommendations do not produce their projected savings, there is a backup plan: a global spending cap. If Medicaid spending increases by more than 4 percent, the Department of Health will take steps to reduce spending. The main avenues for reducing this spending are utilization controls and rate reductions.

New York's global spending cap could indeed control spending, but this can only work over a short period. If enrollment increases, as it is set to do after 2014, this will lead to increased Medicaid costs. As New York's population ages, demand will increase for expensive long-term care services. Simply decreasing reimbursement rates will not address these underlying problems. A spending cap is a budget gimmick, not a realistic way to stop unsustainable Medicaid spending.

Rhode Island

In January 2009 the U.S. Department of Health and Human Services granted Rhode Island a waiver that would allow it to make fundamental changes in how the state operates its Medicaid program. In return for this flexibility, the state has an aggregate budget ceiling of $12.075 billion through 2013.

The waiver grants Rhode Island a variety of options generally unavailable to other states to administer its Medicaid program:

> …a new streamlined and expedited 45 day approval process for any changes to benefits or program during the 5 year demonstration period; establishes new levels of care for the determination of long term care eligibility that will serve to place priority on high quality and less expensive community based placements over costly institutionalized care, and give consumers meaningful choice; allow for benefits in any optional and mandatory program to be "customized" to fit the needs of the person; allow for priority to be placed on preventative services, wellness and personal responsibility; establish a healthy choice account that will reward healthy behaviors with appropriate incentives; allow new purchasing strategies that focus on quality and competition; waive the "any willing provider" Medicaid provisions; and consolidate all 11 waivers with their different rules and policies into one waiver with streamlined regulations that focuses on the consumer over the lifespan.[16]

This is not exactly a block grant, but is fairly close to the type of arrangement seen under a block grant scenario – greater flexibility for the state while the federal government gets budget certainty.

While Rhode Island Governor Donald Carcieri, a Republican, spearheaded efforts to obtain this waiver, he was supported by the Democratic leadership of Rhode Island's legislature. Like New York's reforms, this proposal was championed by a bipartisan group of policymakers concerned about improving Rhode Island's Medicaid system.

Indiana

In 2008, Indiana established the Healthy Indiana Plan, which provides health care coverage for adults who are not eligible for Medicaid and live in families that make under 200 percent of the federal poverty level. The plan offers high-deductible insurance paired with a POWER (Personal Wellness and Responsibility) account (similar to a health savings account).

Its high-deductible insurance offers coverage after the enrollee meets a $1,100 deductible. It has a $300,000 annual cap and a $1 million lifetime cap. The POWER account is administered by the enrollee's managed care plan and can be used to meet the $1,100 deductible. Enrollees must make a mandatory monthly contribution to their POWER accounts. They also receive deposits into these accounts by the state and federal government. Furthermore, enrollees have free access to preventive care.

The Healthy Indiana Plan is allowed under a federal Medicaid waiver and was instituted by Indiana to provide health care coverage to low-income adults without enrolling them in traditional Medicaid.

While the Healthy Indiana Plan shows another way the government can provide health care coverage to low-income people, it still contains some of the same drawbacks of traditional Medicaid. The plan shows signs of fiscal stress, with costs per-enrollee being higher than expected and state revenue not keeping up with the program's cost.[17]

Florida

Florida's Medicaid system, like the system in other states, was growing significantly, with a growth rate averaging 10.4 percent annually from 1990 to 2007.[18]

In 2005, CMS approved a waiver for Florida to establish a Medicaid a pilot program in two counties. This pilot program gave Medicaid recipients a risk-adjusted credit they could use to purchase health care coverage from man-

aged care organizations. This coverage was split in two parts: comprehensive and catastrophic. Comprehensive plans cover the range of relatively low-cost services, such as check-ups, x-rays, and doctors' visits. Catastrophic plans cover the higher-cost services, such as hospitalizations.

The rationale behind splitting the payments in this way is to provide incentives for managed care organizations to compete for patient dollars. In areas with large populations, there is little need to offer distinct payment for catastrophic care, as managed care organizations can spread the risk through a larger pool of payers. In less-populated areas, however, managed care organizations find it difficult to operate, as one high-cost patient may spell financial disaster.

The important take-away for Maryland is not so much the specifics of the task force's recommendations but that a bipartisan group recognized the key to controlling fiscal pressure in his state was fundamentally in reforming Medicaid.

The shortcomings of traditional managed care plans can be seen in New York, which has some Medicaid recipients in long-term managed care. Over 90 percent of those in these systems are in New York City, however. More rural counties do not have any significant amount of Medicaid managed long-term care.[19] In Maryland, expensive long-term care recipients are largely in fee-for-service programs, not managed care.

Another part of Florida's pilot program is an enhanced benefit program that offers recipients credits if they follow certain healthy behaviors. These credits can then be used to purchase additional medical care or, when recipients leave Medicaid, used towards the cost of health insurance premiums.

Florida's Medicaid providers were also granted far greater flexibility in designing their Medicaid benefits packages. Instead of offering a standard benefit package, a provider can offer a package tailored to meet the needs of a certain population, like AIDS patients or pregnant women.

Medicaid recipients also received flexibility to use their Medicaid premium amount to pay their portion of employer-sponsored health insurance premiums.

While some oppose the pilot program, it seems to be controlling costs more effectively than other states' Medicaid programs and providing greater recipient satisfaction.[20] In May 2011, Florida's policymakers approved a plan to expand this pilot program statewide.

MARYLAND'S OPTIONS

Given what other states are doing, what reforms could Maryland undertake to reform its Medicaid program?

Establish a Medicaid Redesign Team. Soon after he was inaugurated, Governor Cuomo of New York established a task force to recommend ways to reform Medicaid. This task force presented a variety of recommendations, some good and some bad. The important take-away for Maryland is not so much the specifics of the task force's recommendations but that a bipartisan group recognized the key to controlling fiscal pressure in his state was fundamentally in reforming Medicaid.

Governor O'Malley should institute a similar task force to examine ways to improve Maryland's system so that it better serves Medicaid recipients while also controlling costs.

Demand Greater Flexibility. Like Rhode Island and Florida, Maryland could apply for a waiver from the federal government that would allow it greater flexibility to administer its Medicaid program.

If Maryland followed the example of Rhode Island, it could consolidate its current five Medicaid waivers to one, reducing bureaucratic overhead. It could also customize its Medicaid benefits to a far greater extent than allowable today.

Rhode Island achieved its flexibility by agreeing to receive a set amount of federal Medicaid funding. It is doubtful that Governor Martin O'Malley would support something this close to block granting Maryland's Medicaid program. In April he co-signed a letter to the Congressional leadership opposing Rep. Paul Ryan's suggestion that federal Medicaid dollars be allocated as block grants to states in return for greater state flexibility in administering the program.[21]

The current administration at the federal Department of Health and Human Services would not likely grant a waiver if Maryland applied for it. Rhode Island received a waiver in the last days of the George W. Bush administration from an agency that was far more open to state flexibility than the current HHS. Even if HHS would turn Maryland down, however, it would force the federal government to explain why a state should not have more freedom to tailor its Medicaid program to meet its needs.

Expand Managed Care. Like the Florida counties in the pilot program, Maryland does use managed care organizations to provide services to many Medicaid recipients. Maryland is similar to Florida in that its managed care rates are risk-adjusted rates. But the Florida pilot program uses managed care to provide more services to more recipients, leading to potentially greater savings for the state's taxpayers.

In Maryland, Medicaid recipients in institutional care, some home and community-based care, and the family-

planning waiver receive fee-for-service care. Services for these populations are expensive and one way to lower the cost growth to serve them is move towards the Florida model.

Providing credits for Medicaid recipients to purchase both comprehensive and catastrophic coverage would help move these expensive recipients from fee-for-service coverage to managed care. If the Florida experience holds true for Maryland, cost savings could result for the state as well as greater satisfaction for recipients.

Alternatively, Maryland could consider what the New York task force recommended, which was move a segment of high-cost long-term care recipients into managed long-term care. This would not achieve as large a fiscal savings, but it would be a more manageable process.

Look for Alternative Ways to Provide Coverage. When Indiana policymakers wanted to expand health care coverage to a new class of adults, instead of enrolling them in traditional Medicaid, Indiana provided a less-expensive method through its Healthy Indiana Plan. When Maryland policymakers wanted to expand coverage, they simply enrolled these people in Medicaid.

As it is forced to expand Medicaid coverage due to the new federal health care law, Maryland should consider creating a system based on the Indiana model to cover these new enrollees. It should also transition current adults with incomes over 100 percent of the federal poverty level into this new program.

Such a plan would give the state a more stable budget process, as it would have more predictability in the cost of these recipients. It would also give these recipients more control over their health care and an incentive to move from Medicaid to traditional health insurance.

CONCLUSION

Unless attempts are made to decrease the growth rate of Medicaid spending, Maryland will continue facing budget problems. Other states have explored diverse options to reduce Medicaid spending in their states. Maryland policymakers should look to these states and see which innovative ideas would be right for its Medicaid program. Maryland need not be a leader in Medicaid reform. Instead, the state can simply copy what is working in other states and reap the benefits of slower program growth and better recipient service.

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